MCO's and DSRIP

September 18, 2015

Healthfirst

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- Provider-sponsored, NFP health plan founded in 1993
- Close to 1.2 million members in downstate NY
  - Medicaid/CHP
  - Medicare Advantage
  - MLTCP, MAP, FIDA, HARP, EP
  - QHP
- VBP with many bells and whistles

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Healthfirst Philosophy

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- Leverage the economies and expertise of an aligned health plan to create synergies with provider partners through a risk sharing/risk transfer environment to deliver high quality, member-centric care
- It's working pretty well
    - Largest and only 4-Star Medicare Advantage HMO in NYC
        - With >60% dual eligible and >80% LIS membership
    - Only 5-Star Medicaid and QHP plan on NYSOH in our region
    - Highest QARR scores on NYS Medicaid incentive for 3 straight years
    - Surpluses have been reinvested in delivery system for many years

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1. “Narrow Networks”

If narrow networks are increasingly prevalent, and if they do indeed help hold down costs, would a migration to narrow networks built around the Performing Provider Systems make sense in the NYS Medicaid program?

- Narrow networks have implications for consumers
- Medicaid benefit not currently configured for narrow networks
  - No member financial responsibility
  - Emergency room

“Hospital Networks: Evolution of the Configurations on the 2015 Exchanges,” a publication of the McKinsey Center for U.S. Health System Reform, April 2015.

2. Care Management

As we move towards DSRIP Year 2, and as we progress through the VBP roadmap, is there a continued role for plans to provide care management services, or should such services be the exclusive responsibility of Performing Provider Systems?

- Downstate NY delivery system overlaps heavily
- Members move around and also change their PCPs
- Members access care from multiple providers
- Complex cases, out-of-area, benefits management require CM
- Goal should be One Care Plan rather than One Care Manager

Deborah Bachrach, William Bernstein, and Anne Karl, "High-Performance Health Care for Vulnerable Populations: A Policy Framework for Promoting Accountable Care in Medicaid, " The Commonwealth Fund, November 2012.

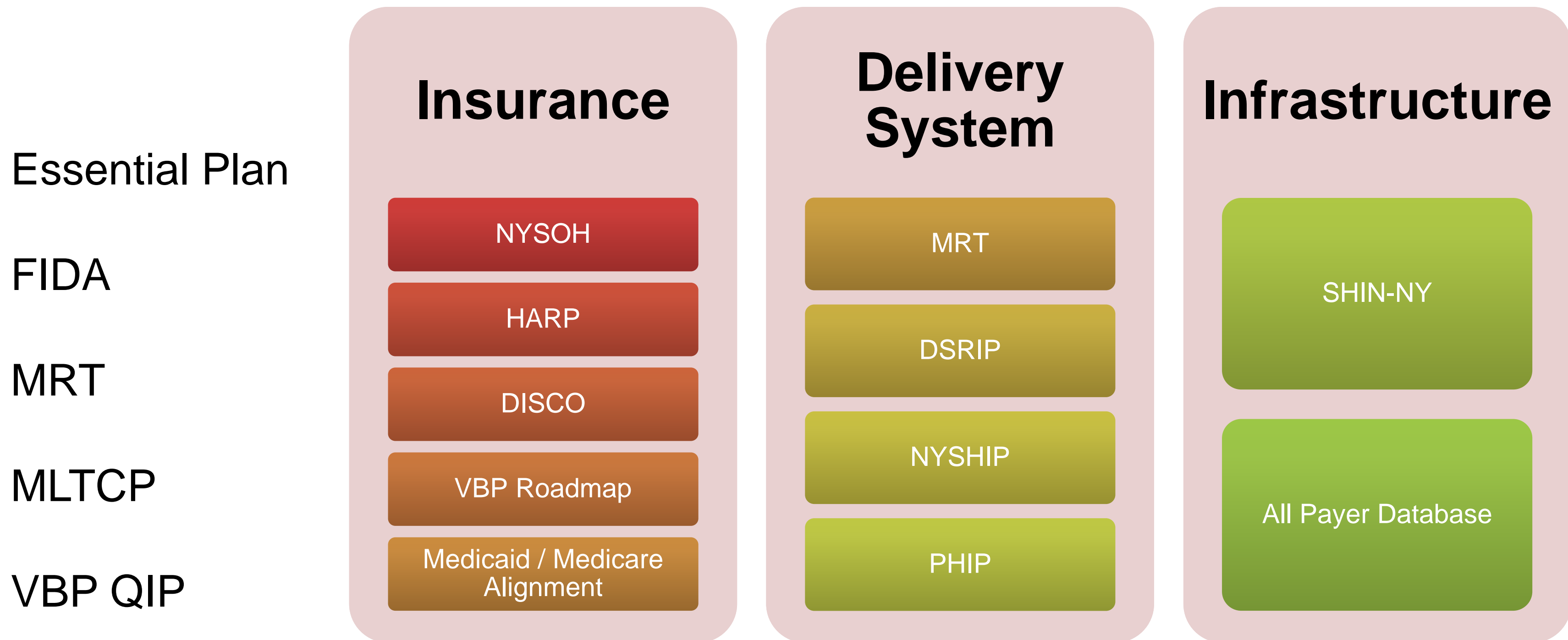
3. Attribution

How will we square the methodology used to assign lives to Performing Provider Systems with the approaches to attribution employed by MCOs, particularly since the infrastructure (2.a.i, 3.a.i) DSRIP funds are building connects the Performing Provider System and its DSRIP attributed lives, which may not overlap with lives assigned to the Performing Provider System by MCOs in the context of VBP contracts?

- It will square over time
- VBP philosophy will be relevant

4. Competing Priorities

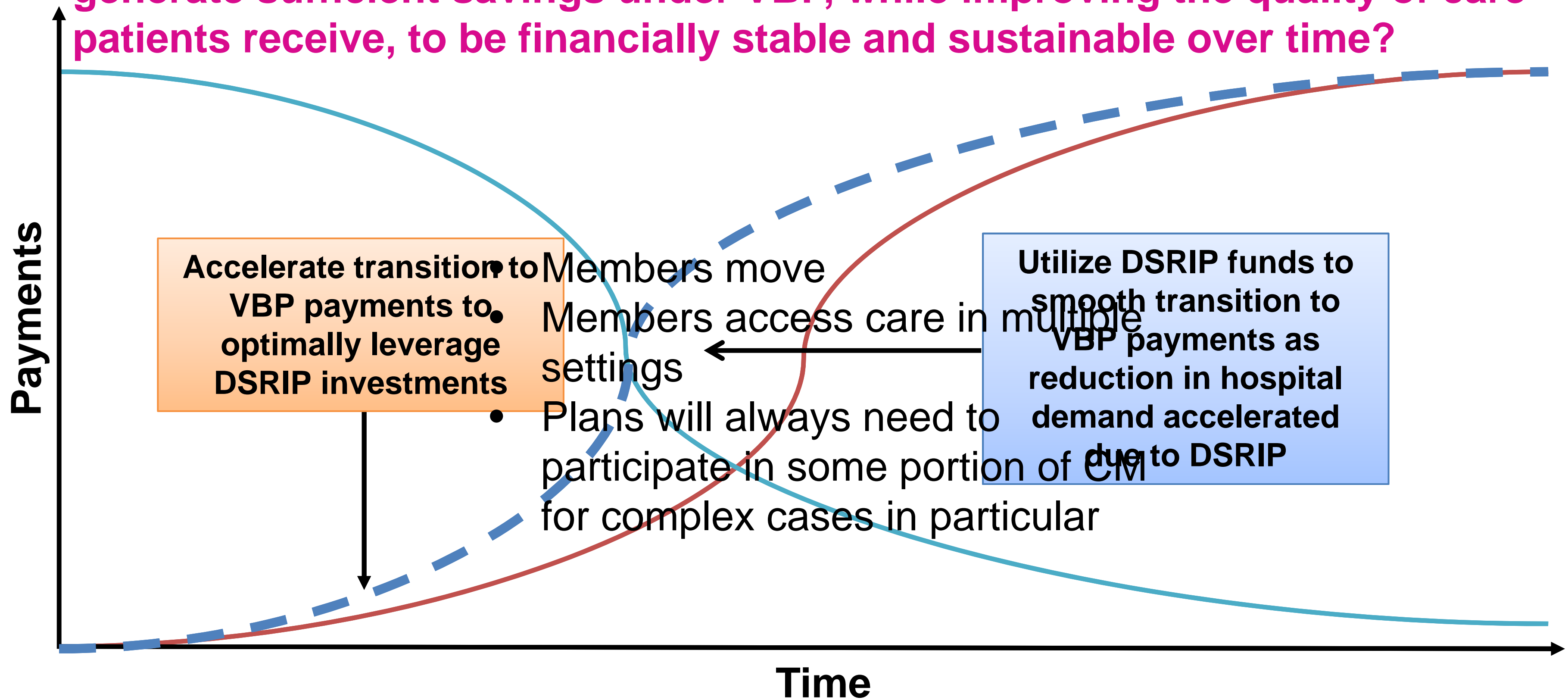
Though there is apparent alignment among all of the State reform initiatives, their sheer magnitude poses immense implementation risks. Do you think we can manage through the execution of all of these initiatives? Do you think there are some that should be prioritized over others?



Courtney Burke, "Connecting the Acronyms: Multiple Reforms, Common Goals," a presentation to the United Hospital Fund Health Policy Forum, December 5, 2014.

6. Business Model under VBP

Are you confident that the Performing Provider Systems will be able to generate sufficient savings under VBP, while improving the quality of care patients receive, to be financially stable and sustainable over time?



- Members move
- Members access care in multiple settings
- Plans will always need to participate in some portion of CM for complex cases in particular

VBP Payments accelerated to offset reduced FFS revenue
VBP Payments at normal pace
FFS Payments - reductions in hospital demand accelerated by DSRIP

Anatomy of a Medicaid Managed Care Premium Dollar (through Q3 2014, NYC & Long Island)

Pharmacy
21%

Personal Care
2%

Diagnostic test, lab & x-ray
7%

Administrative Expenses
9%

Net Income
0%

All other ambulatory, dental/vision, DME, other
20%

Inpatient
23%

Primary/Specialty Care Physician
18%

* Data is based on Q3 2014 MMCOR extracts for HF PHSP, Amerigroup, United, MetroPlus, Fidelis, HIP and Affinity

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7. How Do the Plans Define Success

DSRIP is usually described as aiming to reduce potentially preventable Medicaid admissions by 25% over the course of the five-year waiver period. But the reality is that DSRIP contains numerous intermediate process and outcome milestones and metrics at population, project, and partner levels. That said, what do the Medicaid plans see as important outcomes as a result of the DSRIP-driven efforts and investments that will occur over the next several years? Do Performing Provider Systems need to do anything differently to achieve these outcomes?